Name/HI Number	Date Claim Received	Date Denial Notice Mailed	Processed Within 60 Days?	Denial Proper?	Correct Appeals Language Provided?	Comments

Standard: 95 percent correct.

Determination: Transfer results of this sample to the appropriate requirements at CP01 - CP04 of the *Review Guide*. See Column Explanations for coded requirements related to specific columns.

REVIEW OF DENIED CLAIMS

WS-CP2

Requirement:

The M+CO must assume financial responsibility for ambulance services dispatched through 911, emergency, urgently needed, and post stabilization services as well as temporarily out of the area renal dialysis services that its Medicare enrollees obtain outside the M+CO, without prior authorization.
The M+CO must ~~make all organizational determinations~~ pay or deny all other claims within 60 calendar days from ~~receipt of the claim~~ the date of the request.
If the M+CO makes a determination that is wholly or only partially unfavorable to the enrollee, it notifies the enrollee of its determination within 60 calendar days from ~~date of receipt~~ the date of the request.
The M+CO includes appeals language in its denial notice.

Purpose: To determine whether the M+CO complies with the regulatory requirements to provide notice of an adverse organizational determination and process claims within 60 days of receipt. To determine whether the M+CO has not inappropriately denied services; e.g., Medicare-covered services, emergency and urgent needed care, and benefits covered in the M+CO's subscriber agreement.

Sample: In the notification of site visit letter, reviewer will request the M+CO to provide a list of claims, from unaffiliated and affiliated providers, that were denied in the six-month period ending with the month prior to the scheduled visit (the specific months should be specified in the letter). If contracted provider groups process claims, **be sure to have the M+CO include separate claims listings of the claims denied by its contracting groups.**

Upon receipt of the list, approximately two weeks prior to the site visit, the reviewer will select 30 cases of M+CO claims and 30 cases of group claims (if the M+CO contracts with multiple groups, select a sample that includes claims from at least three groups) in accordance with the random selection methods discussed in the *Review Guide* Instructions, under Sampling Methodology. ***(Note: During focused reviews, HCFA staff may elect to increase sample sizes to 100 cases or more, as deemed appropriate by the Agency.)***

Five (5) to seven (7) days before the site visit, reviewer will notify the M+CO of the specific units of analysis. The M+CO will have all necessary documentation for the units of analysis available upon the reviewer's arrival onsite. **Claims which are denied and create no financial impact on the beneficiary (duplicate claims) are not subject to the appeals process and do not require a denial letter be sent by the M+CO (422.562(c)(2)).** Ensure that duplicate claims are excluded for the claims sample. The reviewer will likewise request that the M+CO provide a list of claims from unaffiliated and affiliated providers/suppliers, that were denied in the six month period ending with the month prior to the scheduled visit. The M+CO must include and specifically identify all claims submitted pursuant to any POS benefit that the M+CO might offer. For specific information on the POS benefit that the M+CO offers, consult either the original approved POS proposal, or the annual POS summary that M+CO is required to submit to the HCFA at the beginning of each year. Copies of both documents should be maintained within each regional office.

Column Explanations:

Name/HI Number: Self explanatory. Number optional. Identifier may be the claim number, as defined by the M+CO's claims processing system; in addition, an enrollee identifier should also be used.

Date Claim Received: Self-explanatory.

Date Denial Notice Mailed (two separate columns): Self-explanatory.

Processed within 60 Calendar Days? Self-explanatory.

Denial Proper? Was the M+CO's denial determination correct? Were claims for emergency and urgent needed care, post stabilization services as well as temporarily out of the area renal

dialysis services processed considering the enrollee's perception at the time the service was received (prior authorization need not be obtained). **Transfer result to CP01.**

Correct Appeals Language Provided? A notice including reason for denial and a description of the appeals process must be sent to the enrollee in all adverse organization determinations.
Does the claims denial notice include appropriate appeals language? Are denial notices sent or are claims just closed out for failure to receive required or requested information?
Transfer results to ~~CP04 and AP03~~ AP04 and AP05.

Comments: Self-explanatory. Include comments here that will help to focus on trends. Also, note that error cases should be redeveloped by the M+CO.

NOTE: Claims which were improperly denied are considered in making the determination of the adequacy of the claims system (~~AM05~~ AM02). ~~If some should have been determined "clean" organizationally, **do not include them** in the calculation for the 30-day requirement.~~